STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G496	B. WING		12/18/2014
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE VESTDALE CT	
BONA VI	STA PROGRAMS I	NC		MO, IN 46902	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W000000					
	This visit was fo	or the investigation of	W000000		
	complaint #IN00	_	1,000000		
	complaint mirror	7130774.			
	Complaint #IN0	0158974:			
	-	TED, federal/state			
		ted to the allegations			
		V149, W157, W331.			
	Dates of Survey:	December 11, 12, and			
	18, 2014.	, , , ,			
	,				
	Provider Numbe	er: 15G496			
	Facility Number				
	AIM Number: 1				
	1 111/1 1 (	.002.00.0			
	Surveyor:				
	Amber Bloss, Ql	IDP			
	The following de	eficiencies also reflect			
	_	accordance with 460			
	IAC 9.				
	Ouality review c	completed January 6,			
	2015 by Dotty W				
		, , ,			
W000104	483.410(a)(1)				
	GOVERNING BO	DY dy must exercise general			
		d operating direction over			
	1				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MU			JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		15G496	B. WIN			12/18/2014
NAME OF B	DOLUBED OD GUDDU IED	<u>!</u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			2333 W	ESTDALE CT	
	STA PROGRAMS I	NC		KOKON	лО, IN 46902	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG	the facility.	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE	DATE
	trie racility.		WO	00104	Toensure that all client	01/23/2015
	Dagad on record	review and interview,	****	JU1U <del>4</del>		01/23/2013
					rights are protected in	
		dy failed to exercise			regards to community	
		nd operating direction			outings,the following	
	<del>-</del>	to ensure client rights			corrective action(s) will be	
		regards to community			implemented:	
	_	f for an emancipated			1) Theinter-disciplinary	
	adult for 1 of 3 s	ampled clients (C).			team (IDT) met on 1/16/15 t	.0
					discuss the policy	
	Findings include	:			regardingcommunity outing	S
					that is currently in place. It	
	The facility's "Co	ommunity Outings"			was decided by the team	
	policy (undated)	was reviewed on			torevise the policy to ensure	
	12/12/14 at 1:55	PM and indicated the			the rights of emancipated	
	facility "actively	works to ensure that all			adults by evaluatingrequests	i e
	clients participat	ing in the program are			for outings on an individual	
	given the opport	unity to participate in			basis to determine if staffing	5
	social, religious,	and community group			isrequired when participatin	g
	activities based of	on their interests and			in outings with friends and	
	choices." The po	licy indicated "while our			former staff of theirchoosing	<u>3</u> .
	efforts are focuse	ed on outings for clients			2) TheVice President of	
	supported by cur	rent staff, management			Residential Services will	
	recognizes and s	upports the fact that			revise the policy to reflect	
		ional relationships may			thesuggestion from the IDT	
	develop among o	elients and staff. When a			team. Upon revision, the Vi	ce
		nployment from the			President of	
	_	difficult for the client,			ResidentialServices will	
		nt to support the client in			submit the policy to the	
		e relationships if he or			Human Rights Committee	
	she chooses. In o	-			(HRC) and agencyBoard of	
		ll be made with the			Directors for review and	
	_	se Manager for the client			approval. If approved, all	
		ed by current staff and			Residential HouseManagers	
	in the management		1			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VP4E11

Facility ID: 001010

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PRINTED: 02/18/2015 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	
		15G496	B. WING			12/18/	2014
NAME OF E	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER				ESTDALE CT		
BONA VI	STA PROGRAMS I	NC	1	KOKOM	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	remain staffed d				and QIDP's within the		
	1	ng or activity with former			Residential Services		
		This will ensure safety			Department will be trainedo		
		of the client at all times			the policy. Record of training	- 1	
	while in the com	munity."			forms will be completed upo	on	
					completion oftraining.		
		2:10 PM during an			3) Toensure compliance,		
	interview, the Vi				this policy will be reviewed		
		ices (VP) stated the			annually to ensure that right	sof	
	1	ting" policy was "not a			clients are protected and		
		they had "just put it in			ensured.		
	writing." The VI	P stated they "put it in					
	writing" to be su	re "current staff" went					
	with clients to or	utings to ensure their					
	"safety." The VP	indicated no "client					
	rights are restrict	ted" by the policy.					
	On 12/17/14 at 4	1:10 PM during an					
		dministrator indicated					
		he policy violated any					
		e Administrator indicated					
	T -	on any community					
	I -	noosing with staff. When					
	_	n emancipated client					
		ngs with friends of their					
		taff, the Administrator					
		ery emancipated client					
	could make those	•					
		dicated she understood					
		d include the procedure					
	to ensure the right	-					
	including those v	-					
	_	go on outings with people					
	of their choosing	5.					

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Event ID:

VP4E11 Facility ID: 001010

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND I LAN	or connection	15G496	A. BUILDING	00	12/18/2014
NAME OF P	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE WESTDALE CT	
BONA VI	STA PROGRAMS I	NC	KOK	OMO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W000149	s#IN00158974. 9-3-1(a)	relates to complaint			
W000149	Based on record the facility failed develop written a prevent client to of 3 sampled client (K) and to medication admissampled clients (Findings include  1) On 12/11/14 a BDDS (Bureau or Disabilities Serv 10/22/14 to 12/1 dated 12/2/14 income home from workshop around and was upset. R	evelop and implement d procedures that prohibit lect or abuse of the client.  review and interview, I to implement and/or abuse/neglect polices to client sexual abuse for 1 lents (C) and 1 additional prevent a major nistration error for 1 of 3 lb).  :  at 3:35 PM, the facility's of Developmental ices) reports from 1/14. A BDDS report dicated "a [Client K] the [facility owned] the 3:30pm on 12/1/2014	W000149	Toensure that established agency policies and procedures for abuse, neglect, andmistreatment clients are implemented at executed as written, the followingcorrective action will be implemented:  1) Allstaff located at 233 Westdale Court (Westdale group home) will be re-trainedon the agency abut and neglect policy. Record of training forms will becompleted upon completi of training. Referto Appendation for Record of Training form be used.  2) OnDecember 2, 2014 workshop put the following	nd (s) (s) se of on ix A i to the

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Event ID:

VP4E11

Facility ID: 001010

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		15G496	B. WIN			12/18/	2014
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ESTDALE CT		
BONA VI	STA PROGRAMS I	INC		KOKOM	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	<u> </u>		DATE
	1 -	ne was upset. [Client K]			immediate measures in place		
	~	first. After a few minutes			forClient C: 1) client C will	be	
		hem that when he went to			escorted to and from the		
		the workshop today that			bathroom by staff; clientC w		
		er followed him into the			only use a single stall restro		
		nt K indicated the client			which are located in the doc		
		his penis in my butt.			area andcafeteria; client C w		
		ed when he told Client C			remain in line of sight of his	,	
	_	The BDDS report			staff at all timeswhile at the		
		Client C was interviewed			workshop; and client C will		
	and admitted to				relocated to a different work		
	-	report indicated Client K			area.		
	_	physical examination and					
	a police report fi	lled. The report indicated					
	the facility "start	ted an investigation					
	immediately." T	he report indicated					
	clients C and K	were suspended from					
	work pending in	vestigation. The report					
	indicated "protect	ctive measures in place at					
	the [facility own	ed] workshop are:					
	[Client C] will b	e escorted to and from					
	all bathroom bre	aks by workshop staff,					
	[Client C] will o	nly use single stall					
	bathrooms at [fa	cility] workshop (which					
	are located in the	e dock area and					
	cafeteria), [Clien	nt C] and [Client K] are					
	no longer in the	same work area/same					
	_	same break times, and					
	[Client C] is in 1:	ine of sight supervision					
		e at the workshop."					
		1					
	On 12/12/14 at 1	1:25 AM during an					
		y service Lead Qualified					
		bilities Professional					

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Event ID: VP4E11 Facility ID: 001010

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	OF CORRECTION	IDENTIFICATION NUMBER:		ULTIPLE COI	NSTRUCTION 00		(X3) DATE COMPL	
		15G496	A. BUI B. WIN	LDING			12/18/	/2014
			B. WII		DDRESS, CITY, ST	TATE ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1	ESTDALE CT	, 211 0022		
BONA VI	STA PROGRAMS II	NC			O, IN 46902			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S	PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCE	IVE ACTION SHOULD BE CED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DE	EFICIENCY)		DATE
	` ` '	ed the allegation of						
	_	inst Client C was						
		ne LQIDP indicated						
		d to the allegation. The						
	-	l Client C stopped when						
		n to stop. The LQIDP						
		C moved here from a						
	state hospital and	d did not come with any						
	information which	ch indicated Client C had						
	the potential to b	e a sexual predator. The						
	LQIDP indicated	l Client C had a history						
	of being a sexual	l abuse victim. The						
	LQIDP indicated	I the safeguards put in						
	place had continu	ued and no further						
	incident had occi	urred. The LQIDP						
	indicated the alle	egation was substantiated						
	and indicated a s	taff member had been						
	terminated becau	ise the investigation						
		e been neglectful of her						
		se her area. The LQIDP						
	•	ff responsible for						
		nt C's area had not been						
		the bathroom at the						
	time of the incide							
	2) On 12/11/14 a	at 3:35 PM, the facility's						
	· ·	of Developmental						
	•	ices) reports from						
		1/14. A BDDS report						
		dicated "[Client B]						
		0/14 and it was reported						
		during her visit with						
		11/27 - 11/30 she was						
	given more units	of Novolog (insulin)						
M CMS-2567(02	2-99) Previous Versions Ob	solete Event ID:	VP4E11	Facility II	D: 001010	If continuation sh	neet Pa	ge 6 of 15

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Facility ID: 001010

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL <b>12/18</b> /	ETED	
		15G496	B. WIN			12/10/	2014
NAME OF I	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE  ESTDALE CT		
BONA VI	STA PROGRAMS I	INC			10, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ented scale prescribed on					
	,	cation administration					
	·	nily member whom					
		] with her medication					
	-	lient B]'s Doctor's visit					
		ordered that [Client B]					
		ing scale." The report					
		s explained and also					
		the MAR when to hold					
		nurse if her glucose					
	, ,	el) under 100. When					
	· ·	family member whom					
		on 11/27 at 1p. (pm)					
	~	1/28 at 4:42p glucose					
		9 at 12:52p glucose was					
	79 and 5:32p glu	acose 89 also, on 11/30 at					
		74, 4:20p glucose 75.					
	[Client B] was g	given 14 units each time					
	that the glucose	was under 100." The					
	report indicated	Client B's prescribed					
	sliding scale of t	the Novolog was as					
	follows:						
	"10 units (Novol	log) 100-150 (glucose					
	level)						
	12 units 151-200	)					
	14 units 201-250	)					
	15 units 250 and	1>250 call nurse for					
	blood sugar						
	_	old and call the nurse."					
	The report indicate	ated "[Client B] was					
	monitored by sta	aff when she returned					
	home with no ad						

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Event ID:

VP4E11

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	COMP	ESURVEY LETED 3/2014
	ROVIDER OR SUPPLIER		B. WIIW	STREET A	DDRESS, CITY, STATE, ZIP CO ESTDALE CT IO, IN 46902	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	indicated Client but were not lim disabilities and disabi	ed 10/22/14 which owing steps:  ugar before each meal. units of Novolog before od sugar is 150 or below. units of Novolog before sugar is 151-200. units of Novolog before od sugar is 201-250. units of Novolog before od sugar is greater than Residential Nurse. units of Lantus at 9  in Changes and not include the to hold the Novolog if sugar was under 100. (medication ecord) indicated the fithe sliding scale of					
	On 12/12/14 at 1 interview, the Q	:35 PM during an IDP (Qualified					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G496	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE ( COMPL 12/18/	ETED
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE ESTDALE CT O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	indicated Client trained on admin sliding scale Nov stated she "thoug administered Client weekend. The Quadministered Client weekend. The Quadministructions in Client Con 12/12/14 at 3 abuse/neglect po Violations of Indicated (undated) indicated Programs strictly any form, neglect mistreatment of a This federal tag in #IN00158974.	:30 PM, the facility licy titled "Prohibition of lividual Rights" red "Bona Vista r prohibits the abuse of t, exploitation or					
W000157	483.420(d)(4) STAFF TREATME If the alleged viola corrective action n	tion is verified, appropriate					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING			(X3) DATE SURVEY COMPLETED 12/18/2014	
NAME OF I	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE /ESTDALE CT	12/10/2011
BONA V	ISTA PROGRAMS I	NC		KOKON	MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	Based on record reversalled to ensure ades safeguards were im an allegation of clies substantiated for 1 of additional client (K.)  Findings include:  On 12/11/14 at 3:33 (Bureau of Development of Deve	view and interview, the facility quate corrective measures and plemented in all settings after ent to client sexual abuse was of 3 sampled clients (B) and 1 ).  5 PM, the facility's BDDS omental Disabilities Services) 14 to 12/11/14. A BDDS 4 indicated "a [Client K] came fility owned] workshop around 14 and was upset. Residential I Residential Nurse asked was upset. [Client K] ignored as few minutes [Client K] told went to the bathroom at the tranother consumer followed form." Client K indicated the put his penis in my K indicated when he told did. The BDDS report ent B was interviewed and hall abuse allegation. The ent K was taken for a physical police report filed. The report y "started an investigation report indicated clients B and	Wo	TAG 00157	Toensure adequate safeguards are in place for Client B, the following correctiveaction(s) will be implemented:  1) OnDecember 2, 2014 workshop put the following immediate measures in place for Client C: 1) client C will escorted to and from the bathroom by staff; client C wonly use a single stall restrowhich are located in the docarea and cafeteria; client C workshop; and client C will relocated to a different work area.  2) Allworkshop staff well trained on the immediate procedures. Record of training forms were complet at the end of the training.	the e be vill om ek vill s be c

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PRINTED: 02/18/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G496	B. WIN	G		12/18/	2014
NAME OF B	DOLUDED OD GLIDDLIED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	C		2333 W	ESTDALE CT		
BONA VI	STA PROGRAMS I	INC		KOKOM	1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	line of sight supervi	ision at all times while at the					
	workshop."						
		25 AM during an interview,					
	-	d Qualified Intellectual					
		ional (LQIDP) indicated the					
	-	abuse against Client B was					
		LQIDP indicated Client B					
		gation. The LQIDP indicated					
		hen Client K told him to stop. ed Client B moved here from a					
		id not come with any					
	_	indicated Client B had the					
		kual predator. The LQIDP					
		and a history of being a sexual					
		QIDP indicated the					
		ace had continued and no					
		occurred. The LQIDP					
	indicated the allega	tion was substantiated and					
	indicated a staff me	ember had been terminated					
	because the investig	gation found her to have been					
	-	ties to supervise her area. The					
		e staff responsible for					
		B's area had not been aware he					
	went to the bathroo	m at the time of the incident.					
	On 12/12/14 at 2:20	PM during an interview, the					
		dicated this was the first					
		sexually abusing another					
		dicated Client B's BSP					
		lan) had been updated since					
		I not been implemented					
		Human Rights Committee					
		indicated no new safeguards					
		esidential setting because they					
		cidents there. The QIDP					
		was not being monitored more					
		was already a group home					
	with 24 hour superv	vision.					
	This federal tag rela	ates to complaint					
	This reactal tag left	nes to complaint					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G496	B. WING		12/18/2014
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	₹		/ESTDALE CT	
	STA PROGRAMS	INC		MO, IN 46902	
BONA VI			KOKO		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	#IN00158974.				
	9-3-2(a)				
W00000	400 400( )				
W000331	483.460(c)	1050			
	NURSING SERVI	orovide clients with nursing			
		dance with their needs.			
	Services in accord	dance with their needs.	W000331	Toensure proper execution of	of 02/01/2015
	<b>.</b>		W 000331	physician's orders for Client	
		review and interview,		the followingcorrective	<b>5</b> ,
	the facility's nur	sing staff failed to ensure		action(s) will be implemented	4.
	a client's protoco	ol and instructions for		TheResidential Nurse will	•
	sliding scale ins	ulin was written as		contact the prescribing physic	ian
	_	physician for 1 of 3		for clarification ofinstructions f	
	sampled clients			sliding scale insulin. Upon	
	Sampled Chemis	(B).		clarification, the ResidentialNu	ırse
				will create a plan for the sliding	g
	Findings include	<b>e</b> :		scale insulin and staff located	
				at2333 Westdale Court will be	
	On 12/11/14 at 3	3:35 PM, the facility's		trained on the plan. Record of	
	BDDS (Bureau	of Developmental		training forms willbe complete	
	`	vices) reports from		upon completion of the training 2) Inthe event that Client B wi	
		1/14 were reviewed. A		leave to visit friend or relatives	
				overnightand/or weekend trips	
	_	ted 12/1/14 indicated		the Residential Nurse will ensu	
		rned on 11/30/14 and it		that all family andfriends that	
	was reported to	the nurse that during her		could potentially administer	
	visit with family	period of 11/27 - 11/30		medications to Client B will	
	•	given more units of		bethoroughly trained on the	
		n) than the documented		sliding scale procedures.	
				Signatures will be obtained to	
	-	on the MAR (medication		indicate verification of training	
		ecord). The family		a. Howwill the facility monito	or
	member whom a	assists [Client B] with her		to ensure compliance?" All Residential Nurses will	
	medication also	attended [Client B]'s		berequired to develop systems	e in
I	l		1	I peredamen in agaginh system:	) III (

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Event ID:

VP4E11

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	LDING	oing 00		COMPLETED	
	15G496		B. WIN			12/18/	2014	
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					ESTDALE CT			
BONA VISTA PROGRAMS INC			KOKOMO, IN 46902					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)						COMPLETION	
TAG				TAG	DEFICIENCY)		DATE	
	Doctor's visit wh	nen the doctor ordered			which they a) conduct weekly	ly		
	that [Client B] will be on a sliding scale."				reviews of allmedication reco			
		ated "it was explained			for all clients residing in the home			
	-	_			b) observe staff on aroutinely	∍ly		
	and also documented on the MAR when			basis to ensure that all				
		act the nurse if her			medications are administered			
	glucose (blood s	ugar level) under 100.		according tophysician's order and agency policy. In the eve				
	When document	ed by family member			and agency policy. In the even a medication error, theResider			
	whom assists her (was) that on 11/27 at 1p. (pm) glucose 78, on 11/28 at 4:42p				Nurse will immediately review			
					medication records for allclient			
	glucose was 64, on 11/29 at 12:52p glucose was 79 and 5:32p glucose 89				residing in the home, not just			
					those that are affected, to ensu			
		1 0			thatno other medication errors			
	· ·	12:54p glucose 74,			have occurred, that staff fully			
	4:20p glucose 75. [Client B] was given				comprehend andunderstand directives for medication			
	14 units each tim	ne that the glucose was						
	under 100." The report indicated Client B's prescribed sliding scale of the Novolog was as follows:							
					MAR(medication administration record), and that medications a			
					being administeredaccording to			
					physician's orders and agency			
	"10 unita (Naval	og) 100 150 (gluogg			policy.			
	"10 units (Novolog) 100-150 (glucose level) 12 units 151-200 14 units 201-250 15 units 250 and >250 call nurse for blood sugar Glucose<100 hold and call the nurse."							
	The report indica	ated "[Client B] was						
	_							
	· ·	iff when she returned						
	home with no ad	verse effects."						
		1:54 PM, record review						
	indicated Client B's diagnoses included, but were not limited to, mild intellectual disabilities and diabetes. Client B's MAR							

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:  15G496	A. BUI	JILDING 00		COMPLETED  12/18/2014	
		100 100	B. WIN			12/10/	2011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BONA VISTA PROGRAMS INC			2333 WESTDALE CT KOKOMO, IN 46902				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF		RRECTION (X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		COMPLETION	
TAG				TAG	DEFICIENCY)	DATE	
	(medication adm	inistration record)					
	indicated "Insuli	,					
		ed 10/22/14 which					
	included the following steps:						
	"1. Take blood sugar before each meal.						
	2. Administer 10	units of Novolog before					
	each meal if Blo	od Sugar is 150 or					
	below.						
	3. Administer 12 units of Novolog before						
		sugar is 151-200.					
		_					
		units of Novolog before					
		od sugar is 201-250.					
	5. Administer 15	units of Novolog before					
	each meal if blood sugar is greater than						
	<ul><li>250 and contact Residential Nurse.</li><li>6. Administer 30 units of Lantus at 9 p.m".</li></ul>						
	p.m						
	Client B's "Insulin Changes and						
	Instructions" did not include the						
	physician's order to hold the Novolog if						
	Client B's blood sugar was under 100.						
	Client B's MAR (medication						
	administration record) indicated the accurate order of the sliding scale of						
	insulin.						
	On 12/12/14 at 1	:35 PM during an					
	interview, the QIDP (Qualified						
	Intellectual Disabilities Professional)						
		/					
	indicated Client B's relative had been trained on administering Client B's						
	sliding scale Novolog but the QIDP						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPI	LETED	
		15G496	B. WIN			12/18	/2014	
NAME OF D	ROVIDER OR SUPPLIER	)		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	ROVIDER OR SUFFLIER			2333 WESTDALE CT				
BONA VISTA PROGRAMS INC				KOKOMO, IN 46902				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX				PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP		NATE CONTINUE		
TAG		LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)		DATE		
	stated she "thought a different person"							
	administered Client B's Novolog that							
	weekend. The QIDP indicated Client B's							
	sliding scale insulin protocol should have							
	been written as the order was prescribed							
	by the physician. The QIDP indicated the							
	facility's nursing staff developed the							
	insulin protocol and left off the part of							
	the order which called for the Novolog to							
	be held if Client B's glucose level was							
	under 100.							
	under 100.							
	This federal tag relates to complaint #IN00158974.							
	//////////////////////////////////////							
	0.2.6(a)							
	9-3-6(a)							

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Facility ID: 001010

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